EXHIBIT 1

DHHR KANAWHA COUNTY
4190 W. WASHINGTON ST.
CHARLESTON WV 25313

Mailing Date: 09/18/18

KENNETH L RICHARDS
[redacted]
CHARLESTON WV 25312

West Virginia Department of Health & Human Resources

Case Name: KENNETH L RICHARDS
Case Number: [redacted]7478
Worker Name: HOLLI F BURFORD
Telephone: (304) 746-2360

7006100201001 4

Medical Assistance (MA)

1. ACTION: You will receive your last Qualified Medicare Beneficiary Coverage benefits in September 2018

2. REASON: You failed to return your periodic report form by the date listed on the form. We still have not received the form. Therefore, your benefits have been stopped.

3. POLICY: West Virginia Income Maintenance Manual Section(s): 1.15.Q, 1.14, 2.2.B.2.

Important Information:

You may request an application from this office and submit it with at least your name, address, and signature.

This institution is an equal opportunity provider.

Fair Hearing: If you do not agree with any decision, you may request a Fair Hearing and/or Pre-Hearing Conference within 90 days of the effective date of the action. If you wish to request continued benefits, you must ask for a Fair Hearing or Conference before the date of proposed closure or reduction. Continued benefits only apply to closures and decreases in benefits. The form to request a Fair Hearing and/or Pre-Hearing Conference is enclosed, but you may request it by phone or in person. The following organization provides free legal services to eligible persons:

LEGAL AID OF WEST VIRGINIA, 922 QUARRIER ST., 4TH FLOOR
CHARLESTON, WV, 25301, 304-343-4481/866-255-4370

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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
PRE-HEARING CONFERENCE AND/OR FAIR HEARING REQUEST FORM

If you disagree with the decision made on your application or the proposed changes in your benefits, you may ask for a Pre-Hearing Conference, a Fair Hearing, or both either orally or in writing. You have the right to be assisted and/or represented by a person of your choice at the Pre-Hearing Conference/Fair Hearing. This person may be a friend, relative, attorney or any other person. A Pre-Hearing Conference is an informal meeting with you, your worker and their supervisor. This meeting is to explain anything you have questions about and for you to explain your situation. This Conference may resolve the problem and eliminate the need for a Fair Hearing. If not, you may proceed with a Fair Hearing. A Fair Hearing is a meeting with you and anyone you choose to have with you, a State Hearings Officer, the Department's representative, and any witnesses you or the Department believes can provide appropriate evidence. The Fair Hearing process is designed to make sure the Department took the correct action on the issue(s) involved.

If you ask for a Pre-Hearing Conference and/or Fair Hearing, due to a decrease or closure of your benefits,before the date of the proposed closure or reduction, your benefits will not be reduced or stopped, pending a final decision. Otherwise, the change will be made, and you may ask for a Fair Hearing or Pre-Hearing Conference within 90 days of the effective date of the actions.
NOTE: If your benefits are being reduced or stopped due to a SNAP review, a mass change (such as the annual Social Security increase) or because you signed a form giving up your right to receive advance notice of this change, your benefits will not be continued, even if you request it, but a hearing will be held.

The DHHR worker will help you make arrangements for transportation to any fair hearing if you cannot provide your own transportation and you so request. Your hearing may also be conducted by phone. Also, the worker will help you prepare for the Fair Hearing, if you so request. To call Client Services in Charleston toll-free, dial 1-800-642-8589.

If you wish to have a Pre-Hearing Conference and/or Fair Hearing, please check below and return the bottom section of this form to your local DHHR Office. The address is on the top of the enclosed notice or can be provided to you by Client Services. You may review the materials in your case record during normal business hours. If you request, we will send you a copy of the manual material or you may view and print the manual material yourself on the internet at: http://www.wvdhhr.org/bcf/family assistance/policy.asp.

{ } I would like to have a Pre-Hearing Conference with my worker and/or supervisor. (You may have a Conference before the Fair Hearing and then proceed with the Fair Hearing if you are not satisfied.)

{ } I want a Fair Hearing before a State Hearings Officer. (You may have a Fair Hearing without a Pre-Hearing Conference.)

{ } I wish to have my Fair Hearing by phone.

{ } Please send me the manual section on which the decision was based.

{ } I wish to continue receiving benefits while waiting for a Pre-Hearing Conference or a Fair Hearing decision. Continued benefits only apply to a decrease or closure: If the Department's decision is upheld at the Pre-Hearing Conference (if you choose not to continue with a Fair Hearing) and/or a Fair Hearing, you may have to pay the Department back for these benefits.

{ } I do NOT wish to continue receiving benefits while pending a Pre-Hearing Conference or a Fair Hearing decision. If the Department's decision is not upheld at the Pre-Hearing Conference or Fair Hearing, DHHR will pay you any benefits you missed during the Pre-Hearing Conference/Fair Hearing Process.

Reason for Hearing/Pre-Hearing Request : _____

SSN (Optional) _____ Phone: _____

Signature: _____ Date: _____

Address : _____

DFA-FH-1 REV.(11/13)

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DHHR KANAWHA COUNTY
4190 W. WASHINGTON ST.
CHARLESTON WV 25313

Mailing Date: 10/04/18

KENNETH L RICHARDS
[redacted]
CHARLESTON WV 25312

West Virginia Department of Health & Human Resources

Case Name: KENNETH L RICHARDS
Case Number: [redacted]7478
Worker Name: HOLLI F BURFORD
Telephone: (304) 746-2360

7003504010019

Dear KENNETH L RICHARDS,

This notice informs you of your eligibility for all assistance programs which may be available to you and your family. It gives reasons if you are not eligible for a benefit(s).

Note: If you currently receive Medical Assistance, the summary information could include eligibility for another Medical Assistance coverage group which is not addressed in the Detailed Notices.

If you have been evaluated for benefits for other months, you will be notified in a separate notice. This summary is for the month of November 2018 only.

Supplemental Nutrition Assistance Program (SNAP)

Name	Begin Date	End Date	Status
KENNETH L RICHARDS	2018-11-01		Eligible

Please see the attached detailed notices for additional information.

EDC1

Qualified Medicare Beneficiary Coverage

1. Action:	2. Reason:
Your Qualified Medicare Beneficiary Coverage benefits will stop. You will not receive this benefit after 2018-10-31.	You did not turn in all requested information.

The following individuals are ineligible:

KENNETH L RICHARDS

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LEGAL AID OF WEST VIRGINIA, 922 QUARRIER ST., 4TH FLOOR
CHARLESTON, WV, 25301, 304-343-4481/866-255-4370

EDR1

SNAP

Amount:	Reason:
Your SNAP will decrease from $ 50.00 to $ 39.00, effective 11/01/18.	The Standard Deduction amount applied to the SNAP income has changed. Your shelter and/or utility costs are less.
Certification Begin Date	**Certification End Date**
2018-01-01	2019-12-31

The following is the list of individuals who are eligible for this benefit. If an individual has been added to the Assistance Group, their name will appear here. If an individual income has increased, this will be stated by the amount it increased by.

If they are affected by the Able-Bodied Adult Without Dependents (ABAWD) 36 month tracking policy, the tracking period will be stated after their name.

KENNETH L RICHARDS

Policy: West Virginia Income Maintenance Manual Section(s):

CH 4, APP B 4.4.2 7.2.3

USDA Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

Notes:

The following information was not verified:

Individual Information

KENNETH L RICHARDS

CHECKING ACCOUNT

Proof of the value of this asset.

You must contact this office and report if the gross income of the individuals included in the SNAP benefit increases to more than $ 2024.00 per month. Gross income is the amount of all unearned income received in a month, plus the amount of earned income before any taxes or other withholdings are taken out. This includes the income of individuals who join your household in the future if the new individual purchases and prepares food with someone in your SNAP benefit, is married to someone in the SNAP benefit, is the parent or child of someone in the SNAP benefit (when the child is under 22 years of age), or exercises parental control over/is under the parental control of someone in the SNAP benefit (when the child is under 18 years of age).

If you are interested in applying for the Tel-Assistance/Lifeline Program to help you save money on your phone bill, an application is available for you at your local Department of Health and Human Resources Office or you can download an application using your My inROADS account on inROADS at www.wvinroads.org.

This notice can be viewed online. Go to www.wvinroads.org and create or log into your inROADs account to view notices / appointments /benefit information.

Other Applicable Information :

SNAP

Vehicle Assets	0.00		
Liquid Assets	600.00		
Real Property Assets	0.00		
Personal Property Assets	0.00		
Lump Sum Assets	0.00		
Burial Assets	0.00		
Deemed Assets	0.00		
Your Countable Assets	600.00	SNAP Asset Limit	3500.00

Your Gross Income	814.00	SNAP Gross Income Limit	1316.00
Your Countable Net Income	507.10	SNAP Net Income Limit	1012.00

Gross Earned Income		0.00
Earned Income Deduction	-	0.00
Gross Unearned Income	+	814.00
Standard Deduction	-	164.00
Medical Expense Deduction	-	0.00
Dependent Care Deduction	-	0.00
Support Payments	-	0.00
Shelter/Utility Deduction	-	142.90
Net Adjusted Income	=	507.10
SNAP Maximum Allotment		192.00
30% Adjusted Income	-	152.10
Recoupment Amount	-	0.00
Your Monthly SNAP Benefits	=	39.00
Your Prorated SNAP Benefits	=	0.00

If you are paid more than once each month, your expected gross income for a month is determined by the following method:

Expected gross income received each week is multiplied by 4.3
Expected gross income received every two weeks is multiplied by 2.15
Expected gross income received twice a month is multiplied by 2

Medicaid and/or WV CHIP

The budget below was used to determine eligibility for KENNETH L RICHARDS

Vehicle Assets	0.00
Liquid Assets	600.00
Real Property Assets	0.00
Personal Property Assets	0.00
Life Insurance Assets	0.00

Lump Sum Assets	0.00
Burial Assets	0.00
Deemed Assets	0.00
Your Countable Assets	600.00

Medical Assistance Asset Limit	7560.00

Gross Income Earned		0.00
Blind Work Expenses	-	0.00
$65 1/2 Disregard	-	0.00
Legal Guard/Committee Fees	-	0.00
Gross Unearned Income	+	814.00
1/3 Child Support Disregard	-	0.00
$20 Disregard	-	20.00
Your Countable Net Income	=	794.00
Your Income Over Medically Needy Limit	=	0.00

Medical Needy Income Limit	1012.00

West Virginia Department of Health & Human Resources
Supplemental Nutrition Assistance Program (SNAP)
IMPORTANT SNAP INFORMATION
FOR ABLE-BODIED ADULTS WITHOUT DEPENDENTS

The following eligibility requirements for the Supplemental Nutrition Assistance Program may affect you if you:

- Are at least age 18 and not yet age 50;

If you are otherwise eligible you may receive SNAP benefits for no more than 3 months out of 36 months unless exempt or you:

- Work at least 20 hours per week, averaged monthly; or
- Participate in a work program, such as one sponsored by the Workforce Innovation Opportunity Act, for at least 20 hours per week, averaged monthly.

NOTE: This policy does not apply in all counties of West Virginia. Your Worker must tell you if you live in a county with time-limited eligibility. These counties are subject to change.

NOTE: If you reside in a county with time-limited eligibility and meet the above criteria, you must report when your work hours are reduced to less than 20 hours per week, averaged monthly. This applies to households with limited income reporting requirements as well.

If you lose eligibility because of the time limit, one way you can become eligible again is by working 80 hours in a 30-day period or participating in a work program for a month. If you become eligible again, you can continue to receive SNAP benefits for as long as you meet all other eligibility requirements, including the work requirements. If you lose your job, you may be eligible to receive SNAP benefits for up to an additional 3 consecutive months in the same 36-month period without meeting the work requirement.

You are exempt or become exempt from these requirements and may continue to receive SNAP benefits, if otherwise eligible, if one of the following applies to you:

- You receive SNAP benefits in a SNAP household that includes an individual under age 18;
- You become age 50;
- You are responsible for the care of an incapacitated individual, whether or not you live with the individual;
- You have been medically certified as unfit for work or you are pregnant;
- You are receiving Unemployment Compensation;
- You are a student enrolled at least half-time in any recognized school, training program or an institution of higher education;
- You are a regular participant in a drug addiction or alcoholic treatment and rehabilitation program;
- You are hired for work of at least 30 hours per week or for work paying the equivalent of at least 30 hours times the minimum wage per week;

If you are not exempt from these requirements and do not meet the work requirements, you may volunteer to be placed in a work activity

If you have any questions, please contact the local office listed on the enclosed notice, or the Customer Service Reporting Center at 1-877-716-1212. You may also create an account and report your changes online at http://www.wvinroads.org.

DFA-ABAWD-1
Revised (11/15)

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Reason for Hearing/Pre-Hearing Request : _____

SSN (Optional) _____ Phone: _____

Signature: _____ Date: _____

Address : _____

DFA-FH-1 REV.(11/13)

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